Nutrition and WIC Services

September 2006

Nutrition and WIC Update

USDA Releases Proposal To Update The WIC Food Package

Pat Dunavan, Nutrition Services Coordinator

After 32 years, the WIC food packages are on the brink of an update. Since the inception of WIC in 1974, changes to the WIC food packages have been minimal. The current proposals will align the food packages with the 2005 Dietary Guidelines for Americans and current feeding practices and guidelines from the Academy of Pediatrics.

Among the proposed changes are the addition of:

Fresh, processed or combined fruits and vegetables for children and women;

Baby foods including meats for fully-breastfed infants, and fruits and vegetables for all infants age 6-11 months

Alternatives to milk including calcium-set tofu, and calcium and vitamin D-rich soy beverage

Canned or dried legumes; and canned beans or peas as an alternative to dried legumes

Canned fish choices (salmon, sardines)

Whole wheat bread or other whole grain options

Reductions in:

Infant formula for partially breastfed infants and for fully formula fed infants age 6-11 months

The quantity of eggs

Milk for children and women

Juice for children and women

The elimination of:

Juice for all infants, substituting baby food fruits and vegetables

Whole milk for participants age 2 and older

USDA is accepting comments on the proposed changes postmarked no later than November 6, 2006. All Local Agency staff are encouraged to send their comments to USDA. The entire proposed rule can be seen at:

http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/pdf/06-6627.pdf.

Inside this issue:

Overcoming Barriers to Breastfeeding in the African-American Community:

Presentation by Katherine Barber at Wyandotte County Health Department, August 6, 2006

Summarized by Martha Hagen, BFPC Program Coordinator

The CDC's Breastfeeding National Immunization Data shows African-American (non-Hispanic) women initiating breastfeeding at a lower rate than any other racial/ethnic group (50.4 percent compared to 70.3 percent for all groups). Kansas WIC statistics are almost identical to national statistics with 50.2 percent of African-American women initiating breastfeeding in the spring quarter of 2006.

Katherine Barber is the founder and Executive Director of the African-American Breastfeeding Alliance (AABA.) "AABA's overall purpose is to raise the numbers of African-American women (and women of African-American descent) who breastfeed; educate African American women about the infant and maternal benefits of breastfeeding; provide valuable resources about breast-feeding; offer on-going support to women who decide to breastfeed; and collaborate with other organizations that have an interest in the health and well-being of African-American women and infants." The following is a short summary of Ms. Barber's presentation.

Historically African-American women breastfed but there were many barriers. Slave women had one day off when they had a baby and could only breastfeed their infant one-time per day. In addition slaves were also used as wet nurses which gave breastfeeding a negative connotation. After WWII black families moved north which split families and caused changes in the traditional African-American family. The US cultural shift from home births to hospital births provided yet another barrier to breastfeeding. The benefits to African-American women for breastfeeding are great. African-American women are two times as likely to die from breast cancer than white women due to later diagnosis and treatment. Breastfeeding can reduce breast cancer and ovarian cancer rates. Breastfeeding can also benefit African-American women in the areas of self-esteem, self-empowerment and weight maintenance. Infants also receive benefits. African-American babies are two times as likely to die from SIDS before their first birthday than white infants. Infant death rate decreased by 50 percent or African-American breastfed infants. Asthma and childhood obesity rates are higher in African-American children which can be re-duced with breastfeeding.

African-American women often do not feel that breastfeeding is the "normal" way to feed their infants and many breastfeeding myths circulate in this population. These are the same myths that circulate in all populations – "If I breastfeed, my breasts will sag;" "My baby is crying, I must not have enough milk;" "I can't work and breastfeed.." Effective communication about breastfeeding is important. The AABA has a booklet specifically for African-American women entitled "An Easy Guide to Breastfeeding for African American Women." For copies contact www.4women.gov or www.aabaonline.com. Ms. Barber has also written a book entitled The Black Woman's Guide to Breastfeeding.

Got New WIC Staff???

When a new WIC employee is hired, we ask that the WIC Coordinator or supervisor contact the State Agency (SA) **as soon as possible** to notify the office and request training material. If you know that someone has been hired to work in the WIC program and you know his/her name and start date but he/she has not begun work yet, you may request the training information and notebook so that the materials will be on-site by the start date.

For a new employee, we are interested in the following information:

New employee name – spelled as desired in the KWIC system. (Required)

KWIC security status desired - Receptionist, Clerk, RN, RD, KWIC Administrator, Breastfeeding Peer Counselor (Required). For information about determining appropriate KWIC security status, see policy ADM 07.02.01 KWIC User Security at www.kdheks.gov/nws-wic.

Start date and desired training start date, if different

Name of person being replaced and date of departure

WIC title for new employee, if applicable. (WIC Coordinator, Breastfeeding Coordinator, Nutrition Services Coordinator, Civil Rights Coordinator)

It is best to make this contact via the special e-mail address set up for staff changes, training, and KWIC security requests: wicstaffchange@kdhe.state.ks.us.

The information can also be telephoned or faxed to the office, but the e-mail address is set up so several staff members see it. If the SA person primarily responsible for the function is out, a back-up can handle the request. It is important to provide as much advance notice as possible. Even though more than one state staff person can take care of the request, there still may be times when no one is in the office to handle a request if immediate turnaround is needed. Do remember that each new WIC staff person should read the Nutrition and WIC Services Policy and Procedure manual as a **first** training step. Each staff person can access the WIC Policy and Procedure manual on-line at: www.kdheks.gov/nws-wic/PPM_Table_of_Contents.htm

Breastfeeding Educator Program 2006

Breastfeeding Educator Program 2006

When: October 11, 12, 13, 2006

Presented by: Debi Bocar, RN, PhD, IBCLC

Where: St. Francis Health Center, Topeka

CEUs: Approved for 30 contact hours by the American Nurses Credentialing Center's Commission on Accreditation and for 30-L-CERPs by the International Board of Lactation Consultant Examiners. Eligible to test for Certified Breastfeeding Educator qualification.

For Registration Information: Contact Martha Hagen at 785-291-3161 or mhagen@kdhe.state.ks.us

Management Evaluation Findings: Rights and Responsibilities Signed and Dated

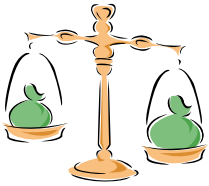
Mary Ann Gabel, WIC Program Consultant

The Rights and Responsibilities form is required by Federal Regulation to be signed and dated by the client or in the case of a minor, the client's caregiver.

Recent Management Evaluation (ME) findings have included an increasing number of these forms that the client/ caregiver has not signed and/or dated. Having the forms dated is just as important as having a signature. The Rights and Responsibilities form is a legal contract between the client and the WIC program. The form sets out the client's responsibilities as a participant in the program, as well as the program's responsibilities to the client.

WIC Coordinators need to ensure that each new or recertifying client or client's caregiver signs and dates the Rights and Responsibilities form by developing a checking procedure that staff using during the certification or recertification process.

For more information about Rights and Responsibilities, go to Policy: CRT 03.02.00 in the Policy and Procedure Manual (PPM), which can be accessed at **www.kdheks.gov/nws-wic/PPM_Table _of_Contents.htm**



Fiscal Fitness

Randy Volz, WIC Fiscal Manager

Beginning October 1, we will embark upon another federal fiscal year – one that promises to involve many new challenges for administering the WIC program. All signs point to a continued shift in the way WIC services are conducted at local agencies, with an emphasis on greater evaluation of and counseling for clients' nutritional needs. KWIC has provided the "equipment" to greatly reduce the time needed to certify clients (no more application forms, files folders, filing of charts, etc.) and have freed up staff time for more nutrition education and other direct services to clients.

There should have been a rather sizeable shift in your staff's efforts, from general administrative work to client services, nutrition education and breastfeeding promotion and support. If your staff hasn't taken the opportunity to shift their efforts yet, they will need to soon! Federal guidelines supporting this shift (such as VENA) are on the way.

As with many new or different ways of doing things, these changes will most likely not be implemented without cost. These costs will most likely be in the form of staff time as well as some new supplies and educational materials. Unlike the Breastfeeding Peer Counselor Program, no additional funding has been earmarked to accomplish these changes. The challenge will be for you to effect change using the funding available in your annual WIC grant. So, your thoughts should be "how can I do what I need to do with the staff and funding I have?" and not "how many new people are we gonna need to hire, and how much more will it cost?"

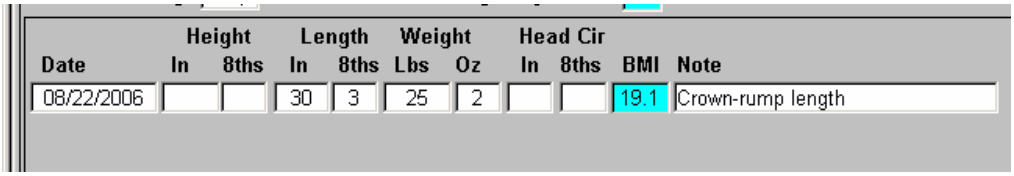
Tto stay fiscally fit, you will need to plan ahead to change your fiscal fitness workout regimen. Don't wait until the 4th quarter to begin warming up! Start exercising your brains now to get a head start on your future fiscal health!

Measuring and Assessing Growth of Children with Special Health Care Needs

Sandy Perkins, Maternal and Child Health Nutrition Consultant

Assessing the growth of children with special health care problems can be complicated. Problems such as an inability to stand, contractures, scoliosis, lack of head and trunk control, and the need to wear braces make some children with special needs difficult to measure using available equipment. Other children with special health care needs can be easily measured, but the resulting data may be difficult to interpret because of altered growth potential. In this article, some potential measurement problems of children with special health care needs are discussed and alternative measurement techniques are reviewed.

It is important to document in the child's record that an alternative measurement technique was used. In KWIC, this should be documented by typing the technique used in the notes field on the measurement tab.



	Height		Length		Weight		Head Cir			
Date	In	8ths	In	8ths	Lbs	Oz	In	8ths	BMI	Note
08/22/2006			30	3	25	2			19.1	Crown-rump length

Measuring of Stature and Length

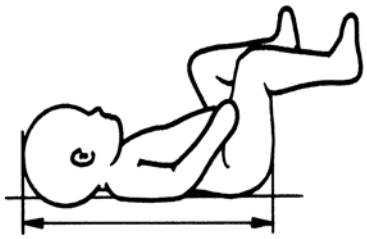
Children who are unable to stand should be measured on a recumbent board as long as possible. Since most recumbent boards have limited capacity, alternative measurements should be used for children taller than 39 inches and children with conditions such as scoliosis and leg contractures that decrease the accuracy of the length measurement.

Alternative measurements describe in this article are:

* crown-rump length and sitting height
* arm span
* upper arm length

Crown-rump length and sitting height

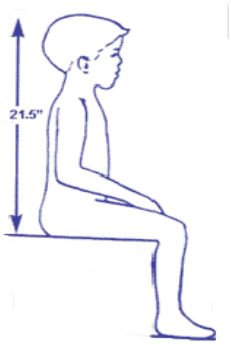
Sitting height and crown-rump length can be used in place of stature and length when a child is unable to stand, but can sit erect.



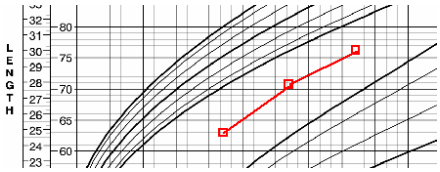
Crown-rump length uses a recumbent length board and requires two people. The first person gently holds the child's head in position, gently cupping the ears to make sure the chin is not tucked in against the chest or stretched too far back. The child should be looking vertically upward and the crown of the head in contact with the headpiece. A second person lifts the legs so the thighs are at a 90-degree angle to the board and held in that position during the measurement. The sliding footboard is brought up against the buttocks with firm pressure and the reading is taken.

Measuring special needs children, continued

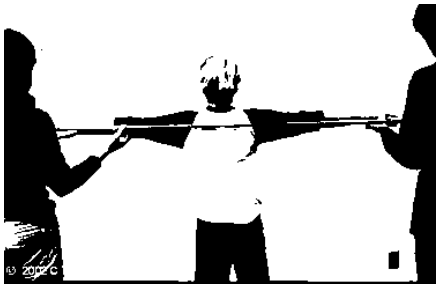
Sitting height is measured using a wall-mounted stadiometer using a sitting base of a known height. The child is seated as erect as possible with buttocks, shoulders, and head in contact with backboard of the stadiometer. Total height is measured. The height of the sitting surface is then subtracted from the total height to calculate the sitting height.



Both the crown-rump and sitting height measurement can be assessed using the CDC charts for stature-for-age or length-for-age. Even if measurements fall below the 5th percentile, it helps establish a growth pattern over time. A series of crown-rump or sitting height measurements parallel to the percentile lines on the stature-for-age charts indicate the child is growing well.



The risk factors Short Stature, Overweight or At Risk of Overweight should be unassigned for any child measured using either the crown-rump or the sitting height technique. Make a note on the Notes Tab in KWIC that the risk factors were unassigned.



Arm span

An arm span may be measured when the child is too long to measure on the recumbent board and is unable to stand or sit erect but is able to fully extend the arms. Arm span measurement requires two people to complete measurements. The child extends both arms perpendicular to his body, while a measuring rod is held across the back, extended from the tip of one middle finger to the other. The measuring rod should be touching the extended middle fingers of the right and left hands. When accurately measured, an arm span correlates well with stature and can be plotted and assessed using the CDC charts for stature-for-age or length-for-age.

Segmental lengths: Upper arm length and lower leg length

For some children who are unable to stand, fully extend their arms or stretch out on the length board, stature measurements are impossible. For these children, segmental lengths can be used to monitor growth. Since lower leg length is a difficult measurement to take and is not recommended for children under age 6, this article only discusses upper arm length.

Upper arm length is the length from the most lateral point of the shoulder blade to elbow. To measure upper arm length the arm should be close to the side of the chest and the forearm should be held at a right angle to the upper arm.

As with the crown-rump and sitting height measurement, segmental lengths can be assessed using the CDC charts for stature-for-age or length-for-age to establish a growth pattern over time. Reference data do exist for some segmental lengths (e.g., knee height), however the data are old and does not include children with special health care needs so it may not be accurate.

Measuring special needs children, continued

The risk factors Short Stature, Overweight or At Risk of Overweight should be unassigned for any child measured using segmental length. Make a note on the Notes Tab in KWIC that the risk factors were unassigned.

Weight measures

Weight should be measured on beam-balance or digital scales, without braces or casts if possible. If braces or casts cannot be removed, document that the weight includes the brace or cast including a brief description of the apparatus. The risk factor Overweight or At Risk of Overweight should be unassigned for any child weighed with a brace or cast. If known, the weight of the brace or cast can be subtracted from the child's weight. In situations where equipment is limited to standing scales, it may be necessary to weigh someone (for example, a parent or caregiver) holding the child, weigh the parent or caregiver alone, and then subtract the weight of that person from the weight of the two together. Be sure to document the method used to weight the child on the measures tab in KWIC.

In conclusion, weighing and measuring children with special health care needs can be difficult. Do the best you can and be sure to document method used.

Check This Out!

Pat Dunavan, Nutrition Services Coordinator

"It's not about counting calories. It's about what counts in your life." This site uses this premise as it presents a variety of information and tips on successful weight loss. An emotional inventory, tips for preventing relapse into unhealthy eating patterns and 15 behaviors of people who manage their weight successfully are only a few of the tools you will find on this Web site www.brighamandwomens.org/healtheweightforwomen.

Need materials for children diagnosed with Type 2 Diabetes? Then check out the materials available from the National Diabetes Education Program at the National Institute of Health at www.ndep.nih.gov. Fact sheets written at the sixth-grade reading level and field-tested with young people from a variety of ethnic groups are available on diet, weight control, and physical activity.

Are you wondering about the health status of women and children in Kansas? Then check out the 2204 Maternal and Child Health summary report published by the Bureau of Children, Youth and Families at KDHE. The report can be downloaded at www.kdheks.gov/bcyf.

Did you know that the Center for Nutrition Policy and Promotion is offering free continuing professional credits for dietitians and dietetic technicians for reviewing certain MyPyramid materials on their Web site? See www.cnpp.usda.gov/CPEcreditis.htm for more information.

Nurses and dietitians can also get continuing education credits for completing the training modules on the WIC Works Resource System. Set up an account and the system will track your completed modules. At the end of the training, instructions are provided on getting a certificate and applying for continuing education credit. Check it out at www.nal.usda.gov/wicworks/. Click on the WIC Learning on-line icon.

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WE'RE ON THE WEB!

WWW.KDHEKS.GOV/NWS-WIC

Growing healthy Kansas families

Local Agency News

We welcome these new WIC employees:

Douglas County, Dee Evans, Clerk
Douglas County, Emily Graves, Clerk
Douglas County, Dianne Summerville, Clinic Assistant
Johnson County, Shannon Williams, Clerk
Marshall County, Joyce Milner, RN

We say farewell to these WIC friends:

Harvey County, Trish Schimming, RD
Jackson County, Charlott Blanton, Clerk
Marshall County, Jean Heinen, RN
Sedgwick County, Joyce Allen, Administrative Assistant

Congratulations to Randy Volz, WIC Fiscal Manager, who is the newest member of the National Advisory Council on Maternal, Infant, and Fetal Nutrition.